A bill for an act

relating to human services; authorizing a rate increase for publicly owned nursing facilities; changing the all-inclusive care for the elderly program (PACE); requiring a local share of nonfederal medical assistance costs; appropriating money; amending Minnesota Statutes 2008, sections 256B.19, by adding a subdivision; 256B.441, by adding a subdivision; Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2008, section 256B.19, is amended by adding a subdivision to read:

Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning January 1, 2011, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d). Payments of the nonfederal share shall be made monthly to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph (d). Payments for each month beginning in January 2011 through September 2015 shall be due by the 15th day of the following month. If any provider obligated to pay an amount under this subdivision is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a.

Sec. 2. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between January 1, 2011, and September 30, 2015, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other RUG's levels shall be computed as provided under subdivision 54.

(b) Rates determined under this subdivision shall take effect beginning January 1, 2011, based on cost reports for the rate year ending September 30, 2009, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

(c) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by September 30, 2010. Participation under this subdivision is irrevocable. If paragraph (a) does not result in a rate greater than what would have been provided without application of this subdivision, a facility's rates shall be calculated as otherwise provided and no payment by the local government entity shall be required under paragraph (d).

(d) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under subdivision 54, paragraph (a), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 55 as determined by the commissioner.

(e) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 3. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to

9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until four years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. ~~The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs.~~ A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of

care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods for contract years starting in 2012, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract years 2010 and 2011 for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted

case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 4. **APPROPRIATIONS.**

Subdivision 1. **Community service development reduction.** The appropriation in Laws 2009, chapter 79, article 13, section 3, subdivision 8, paragraph (a), for community service development grants, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, paragraph (a), is reduced by $154,000 in fiscal year 2011. The appropriation base is reduced by $139,000 for fiscal year 2012 and $0 for fiscal year 2013. Notwithstanding any law or rule to the contrary, this provision expires June 30, 2012.

Subd. 2. **Health care administration; PACE implementation funding.** For fiscal year 2011, $145,000 is appropriated from the general fund to the commissioner of human services to complete the actuarial and administrative work necessary to begin the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $130,000 in fiscal year 2012 and $0 in fiscal year 2013.

Subd. 3. **Continuing care management; PACE implementation funding.** For fiscal year 2011, $111,000 is appropriated from the general fund to the commissioner of human services to complete the actuarial and administrative work necessary to begin the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $101,000 in fiscal year 2012 and $0 in fiscal year 2013. For fiscal year 2013 and beyond, the commissioner must work with stakeholders to develop financing mechanisms to complete the actuarial and administrative costs of PACE. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care funding by January 15, 2011, on progress to develop financing mechanisms.

Sec. 5. **EFFECTIVE UPON FEDERAL APPROVAL.**

Sections 1 and 2 shall be implemented only upon federal approval. The commissioner of human services shall delay the effective date of sections 1 and 2 if necessary in order to avoid loss of enhanced federal Medicaid matching funds as authorized by the American Recovery and Reinvestment Act of 2009 and extended by any subsequent law.